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Qs & As

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VA Takes Another Major Step in National CARES Planning Process

What are the timelines for completing the various steps in the CARES process?
The key stages are:

1. Market areas established	July '02
2. Analysis of needs	Aug. Sept. Oct. '02
3. Planning Initiatives identified	Nov. '02
4. Market Plans submitted	Feb. '03
5. Headquarters review	March, April '03
6. CARES Commission review begins	June, July, Aug. '03
7. CARES Commission recommendations made	Sept. Oct. '03
8. Secretary's decision	Oct. 2003
9. Implementation	Ongoing

What are "Planning Initiatives" and who will develop them?

Basically, "Planning Initiatives" are the gaps, with both the positive and negative differences, between current supply and future demand through 2022. Factors such as workload, facility location, access, space and health care needs were analyzed. Basically, this stage of the process is a needs assessment. During December, January and February, the Networks will focus on resolving the needs identified by the Planning Initiatives. They will develop draft Market Plans in cooperation with all parts of the VA department, the Department of Defense, affiliates and local communities.

What are the data sources VA is using to determine Planning Initiatives?

For CARES Phase II, VA is using a variety of data sources, including:

1. Projections from adjusted 1990 Census data;
2. Military separations and projected separations (using the Defense Department's model);
3. VA's Compensation and Pension file. This file identifies veterans with disabilities and can help determine migration patterns (studies show that veterans are twice as mobile compared with the general population as a whole); and
4. Enrollee projections (prepared by an outside contractor). Current and projected enrollee data will be analyzed by county (or zip code for urban areas), age group and enrollment categories.

Why isn't VA using any data from Census 2000?

The veteran-related Census 2000 data currently available do not provide enough detail to use for CARES planning purposes. For example, no information is yet available by age and sex at the county level. Initial comparisons between the 1990 and Census 2000 data shows a difference of less than three percent of the actual

numbers in more than 2900 of the 3000 counties in the United States. However, there may be more differences between the 2000 and 1990 Census data in some areas of the country. Census 2000 data will be incorporated in the model when it becomes available in 2003 and will be taken into consideration by the Networks when developing the Market Plans.

What are the criteria to be used in evaluating Planning Initiatives?

The criteria are:

1. Health care quality and need (whether the initiatives impact the quality of care and whether the initiatives meet the identified gaps in services);
2. Safety and environment of care;
3. Appropriate access to care (travel time);
4. Impact on employees and communities;
5. Impact on research and education programs;
6. Impact on community health care providers;
7. Support of other VA missions (VA-DoD collaboration, collocation with other VA administrations, VA's contingency role as medical backup to DoD, VA's role in homeland security and emergency preparedness); and
8. Optimizing the use of VA resources (cost-effectiveness, "right sizing" and realigning facilities based on future demand and needs).

How did VA project data on veteran enrollment for VA health care?

VA estimated how many veterans there will be in the years to come and how many of them will enroll in VA health care. To estimate how many veterans there will be, VA counted how many there are and then for each future month, added the number of new veterans expected to be discharged from the Armed Forces and subtracted the number of estimated deaths.

Predicting how many veterans would enroll was difficult and VA had to make some assumptions based on veterans' choices during the relatively short time since enrollment started. To lessen the chance of error, VA estimated specific enrollment rates for veterans in three age groups and in each of the enrollment priorities. This was done separately for veterans who were VA patients before and after enrollment started. All of these different rates were estimated for every county in the United States.

Then VA multiplied the predicted number of veterans with the predicted enrollment rate to get the predicted number of enrolled veterans.

With a shrinking veteran population, how can VA project increasing enrollment?

Enrollment rates are calculated for each age group, gender, priority level, county and enrollee type (pre or post enrollment). As the veteran populations' age structure and priority distribution change with time, total enrollment changes. Increased enrollment occurs when new projected enrollment exceeds the reductions in enrollment due to death. This results in increasing market shares for all priority levels except priority

level 1. Enrollment levels begin to decline at various times, depending on the priority. Total enrollment levels begin to decline after fiscal year 2013.

Does the CARES veteran population model take into account Gulf War and Bosnian War veterans?

While we are not separating the data by specific conflicts, the model uses factors such as age, gender and priority. Consequently, veterans of the Gulf War and Bosnian War are included in the model.

Why can't Networks have more time to develop their Market Plans?

Admittedly, the CARES timeline is very ambitious. There are relatively short turn-around times for Networks to develop their Market Plans. However, VA headquarters has populated the data base that the Networks will use to submit their Market Plans, which will save some time. The timeline for the Under Secretary for Health to review and develop a draft National CARES Plan has also been reduced. However, it is critical to adhere to this schedule so the CARES Commission has the time it needs to review the plans, consider views and concerns presented during the 60-day public comment period, hold public hearings, conduct site visits and develop recommendations to the Secretary.

Time for veteran and stakeholder involvement is critical. Will veterans and other stakeholders have input into the development of the Market Plans?

Networks have 90 days to develop Market Plans (solutions) to the Planning Initiatives (gaps). This 90-day period is the most critical time for stakeholder involvement. Nevertheless, veterans and stakeholders are not limited to providing input during that time. In fact, veterans and stakeholders are encouraged to be actively involved throughout the entire CARES process. To assure that veterans and stakeholders' concerns are properly addressed, an independent CARES Commission will be appointed by the Secretary of Veterans Affairs. The Commission will consider views and concerns presented in writing during the 60-day public comment period following submission of the initial recommendations by the Under Secretary for Health and in public hearings held by the Commission.

What interaction has VA and Department of Defense (DoD) had? Was there coordination when drafting the Planning Initiatives?

VA and DoD have collaborated closely throughout the CARES process. DoD provided resource people for the Planning Initiative selection process, who were active participants in reviewing each of the market areas. For instance, DoD reviewed VA's market areas and future population and demand data in relationship to their health care delivery sites to identify sites where they think collaboration is feasible. DoD is also a participant in the weekly CARES Planning Group Meetings. The Planning criteria for CARES specifically address VA's role in providing medical back up for DoD. Additionally, Networks are working closely with their local DoD counterparts and will be looking for possible DoD/VA sharing agreements.

Will cost savings realized from CARES stay within the Network?

Yes. Savings that result from CARES initiatives will stay in the VISN to support local health care enhanced services.

More than 265,000 veterans are currently on waiting lists for VA health care. How does that impact the CARES planning process and decisions?

CARES will help us make predictions about what health services veterans will need in the future and where those services will be needed. It is based on projected enrollment numbers and assumes that VA will provide all eligible veterans with the level and types of care they are projected to need. Because the projections are based on veteran enrollees and not users of VA hospitals and clinics, current waiting lists or waiting times do not limit the projected needs.

The CARES model bases future use on a modern medical system with minimal supply constraints such as the fee-for-service system that provides care to people with Medicare and private insurance. Of course these projections will be adjusted for the veteran population for factors such as age, gender, veteran entitlements and health status.

Moreover, waiting lists are an example of why CARES is so important. Once complete, this initiative will allow VA to reduce costs associated with maintaining unnecessary space, plan for needed clinics in the areas of high demand and improve existing infrastructure and services.

With new technology present, what plan of action has or will be addressed with items such as telemedicine?

Each Network is expected to consider current and expected technology when developing their Market Plans. Telemedicine could be an effective way to address service gaps identified by a Planning Initiative.

What assumptions are made about access and travel times?

Standards for distance and travel times for various population densities (urban, rural, and highly rural) and types of care (primary care, specialty ambulatory care, extended care and hospital care) were developed and used in defining each Market Area. In addition to specific travel times, sub-markets may also be based on considerations such as highways and natural barriers like mountains. The CARES process provides predictions about what health services veterans will need and where those services will be needed. The plans the Networks develop to meet those needs will have to comply with access and travel standards:

	Urban	**Rural**	**Highly Rural**
Primary Care	30 minutes	30 minutes	60 minutes
Inpatient Hospital Care (Med/Surg/psych)	60 minutes	90 minutes	120 minutes
Tertiary Hospital Care	3-4 hours	3-4 hours	Within VISN

Does CARES address long-term care and services for the seriously mentally ill?

Yes. Long-term care services are included in the model. Skilled nursing and extended care are projected using VA data for our utilization patterns adjusted for the predicted veteran enrolled population.

While the CARES model provides a sound basis for predicting the needs of most veterans, the predictions of the model for planning for our special populations are less reliable - due to the relatively small numbers involved and the lack of utilization (workload) benchmarks with unconstrained supply. Therefore, planning for health care for veterans with spinal cord injuries, blinded veterans, and veterans with serious mental illness is based on specific models developed in consultation with specialty clinicians and veterans' advocates.

Will VA analyze the demand for special veterans' programs such as spinal cord injury and blind rehabilitation?

Yes. In addition to spinal cord injury and blind rehabilitation, VA also will analyze the demand for programs and VA's capacity in substance abuse, traumatic brain injury, homelessness, seriously mentally ill veterans and post-traumatic stress disorder. As required by law, current special programs will not be reduced.

Are the Millennium Bill mandates being considered in the CARES planning?

Yes, all current legislative and policy requirements will be considered in the CARES planning process. If policy or legislation changes then the model forecasts will be amended to reflect those changes.

If the CARES model uses private sector benchmarks, won't that skew VA forecasts since the private sector demand is impacted by profit?

The model for projecting demand for VA health care services is based on private sector use rates for Americans with comprehensive health care coverage. American health care is considered the world "gold standard" so matching to the health care utilization of the insured populations is reasonable. VA utilizes the very loosely managed care or essentially fee-for-service standards in its match to the private sector. As a result, if there is a systematic bias, it should not be present in our forecasts.

Priority 7 enrollees will probably make up most of the enrollment growth and they have lower morbidity and reliance? How is this reflected in the model?

Morbidity factors are not priority specific. The actuary calculated morbidity factors for all VA users by age (greater and less than 65), gender, and region for inpatient and outpatient care. The model applies these factors to estimate demand for health care services by all projected enrollees. On the other hand, reliance rates are priority-specific for each VISN, enrollee-type (pre or post enrollment) and age.

How will CARES impact VA employees?

It is too early in the process to speculate on how health care realignments and enhancements will impact VA employees. Employees are important stakeholders and are encouraged to provide input throughout the CARES process. The CARES planning process requires that Market Plans contain strategies to minimize any adverse impact on employees. It will be another year before the National CARES

Plan is presented to the Secretary for decision. Upon receiving approval for the National Market Plan, each Network will develop a comprehensive implementation plan. A key part of the implementation plan is identifying how stakeholders will be kept informed and involved in the implementation process. Every effort will be made to minimize the impact on employees and patients. If warranted, staff reductions will be accomplished gradually through attrition, early retirements, reassignments to programs where services are being enhanced and reassignments to other locations.

Is VA working with employee unions?

Absolutely. On Sept. 24, 2002, VA signed a memorandum of understanding with the American Federal of Government Employees, AFL-CIO, National Veterans Affairs Council #53 (NVAC) regarding CARES nationwide. Essentially both parties agree that labor represenatation will be on all workgroups and/or task forces at the VISN and facility level.

What method was used to forecast the specific skills needed for future health care staffing?

While there is no work-force planning component in the demand model itself, staffing will be considered as part of the development of the Market Plans.

Were the Planning Initiatives calculated based on 2022 demand projections?

Planning Initiatives were identified after reviewing the 2012 and 2022 data. A Planning Initiative (gap) that is not apparent in 2012, but is significant in 2022, or visa versa, was evaluated more extensively to determine if it should be identified as a final Planning Initiative.

Will data be available for sub-markets to respond to Planning Initiatives?

Planning Initiatives were identified for market areas. However, demand data will be provided for sub-markets and facilities, as well as market areas. That may assist in addressing the Planning Initiatives to develop solutions that are sub-market specific even though the Planning Initiative is identified for the market area as an entirety.

Why are projections based on enrollees instead of users for forecasting workload?

VA wants to plan for all enrollees, current and future, not just those who have used the system in the past.

Does the forecast model treat all enrollees as one group?

No. Enrollment forecasts are done separately for three groups. The first group is made up of veterans who <u>used</u> the VA Health Care System during fiscal years 1996-98 (pre-enrollment) and who are currently enrolled. The second group is comprised of veterans who <u>did not use</u> VA Health Care during fiscal years 1996-98 (pre-enrollment), but are currently enrolled in the VA Health Care System. The third group is made up of veterans who enrolled during 2000 and later. Veterans who enrolled in VA Health Care later than 1998, have a lower morbidity (severity/number of health problems) and reliance on VA for their health care compared to the group of veterans who used VA Health Care during 1996-98.

Has VA contracted out the actuarial data? If so, who has the contract?

VA contracted with CACI/Milliman to develop a CARES Enrollment and Utilization Forecasting Methodology.

Does the model account for veterans being treated in more than one VISN?

The model assigns projected enrollee workload based on the preferred facility designated by enrollee and treating facilities of current enrollees.

How is reliance on VA for health care calculated?

Where a veteran received care was determined from surveys of enrolled veterans conducted 1999 - 2000 and an analysis of VA/Medicare use in 1999. Reliance factors (dependence on VA for health care) were developed for age group, enrollee type, priority level and VISN.

Is projected health care use adjusted for age?

Age is an excellent determination of health care use. In general, health care utilization rates per 1,000 enrollees for the 65 or older population is higher than for a younger population. The utilization rates in the model reflect the greater use rates with the growth of veterans 65 or older.

How do we apply cost information from the model?

The CARES Planning Initiative and costing template enables the Networks to compare the costs and savings associated with implementing proposed Market Plans. Many of the costs come from the same VA data used in the budget model, but there are others such as leasing, renovation and construction costs that are not used by the VA budget model.

How often will the model be updated to capture changes in enrollment?

The model will be run annually as part of the VA budget development process. However, the process to be used to update the model has not been determined.

How will CARES handle maintenance, renovation and new construction projects?

Some maintenance, renovation and construction projects will be developed as a result of the Planning Initiatives. New projects will be required to have CARES approval and be included in the capital investment plan. Other projects that are not developed from Planning Initiatives will need to be analyzed for consistency with CARES' forecasted demand for inpatient and outpatient services and whether their location improves accessibility to services.

When looking at projections of vacant space, has there been any consideration given to use that space for state nursing homes or VA nursing home beds?

Yes. Networks will certainly explore using vacant space to meet other identified needs. When developing their Market Plans for use of vacant space, Networks will be expected to identify the strengths, weaknesses, opportunities and obstacles of various options. Networks will have extensive data to assist them in determining the suitability of adapting vacant space for other purposes.

Will CARES have a standardized construction cost database?

Yes. The Planning Initiative/Costing Template will contain standardized construction and renovation costs that are VISN specific and locality specific where possible. This

will enable construction costing to be standardized and estimated consistently. In addition, leasing & demolition costs will be estimated consistently across the system and be available in the template.

What are the possible alternatives for buildings that are determined to be excess or unsuitable for the delivery of modern health care?

One possibility is an enhanced-use lease. An enhanced-use lease is a VA-private sector joint business venture that benefits both parties. These leases provide VA with an economical way to acquire goods, services and facilities at reduced cost. In such an arrangement, typically underused or excess VA property is leased to the private sector for a nominal rent. The private sector then finances and develops the property for a non-VA venture. In return, VA receives substantial discounts, facilities, services and/or revenue.

An example is the plan for an enhanced-use lease for a privately financed, developed and managed office and parking garage complex on the grounds of the West Side Division of the VA Chicago Healthcare System. The project will provide VA with access to parking spaces for veterans, volunteers, visitors and staff at no charge.